EXHIBIT 1

UNITED STATES DISTRICT

FOR THE DISTRICT OF MASSACHUSETTS

IN RE: PHARMACEUTICAL	)	MDL NO. 1456
INDUSTRY AVERAGE WHOLESALE	)	CIVIL ACTION
PRICE LITIGATION	)	01-CV-12257-PBS
THIS DOCUMENT RELATES TO	)	
U.S. ex rel. Ven-a-Care of	)	
of the Florida Keys, Inc.	)	
v.	)	No.06-CV-11337-PBS
ABBOTT LABORATORIES, INC.,	)	

(cross captions appear on following pages)

Deposition of HARRY LEO SULLIVAN

Volume I

Nashville, Tennessee

Tuesday, March 12, 2008

9:05 a.m.

you're talking specifically about a MAC process?
Q. The data that would tell me essentially what was paid and how it was determined what would be paid.
A. Nothing in the computer will tell you how the price was determined. But there should be records of -- because that was all manually input at that time. And I, I'm the one that did it.
I would literally go -- I could log into the mainframe and change prices. It would put a date on there. It would even print an audit trail, of any changes, because, you know, I had a user name and anything I did in that computer there was an audit trail printed out to -- and I guess, I would assume, some taped copy as well.
And you needed that because, and you needed historical information in the claims processing system because Medicaid claims typically can be submitted all the way back 365 days a year.

But you may have cases like SSI determination that may take two or three years for the patient to be determined SSI eligible, automatically Medicaid eligible, and they can submit back from the beginning of that determination period all their pharmacy claims.
So you have to be able to process those claims and pay the price that was appropriate at that time of dispensing.
There should be records of that.
Q. We'll talk about the MAC program a little bit later, but if you wanted to change a price for a particular drug, you had the ability to go into the computer and change the price?
A. Yes. I did. I don't -- I wouldn't say that was true in every state.
Q. Okay. What authorities, if any, would you have to go through in order to change a price for a particular drug?
A. That was my responsibility. I, I, I would do it as part of my job, as part of making sure that -- two things occurred, particularly

with multi-source drugs. One, is that we didn't pay too much. And, two, is that we paid enough to insure an incentive for pharmacists to take the extra step to, if necessary, call a physician and get the prescription changed to a multi-source drug.
Q. And when you talk about an incentive you're talking about a financial incentive?
A. Yes.
Q. And what kind of financial incentive would you provide?
A. What, what I tried to make sure I did during this time, this -- I would say from '89 to '94, was, was make sure that there, there was profit to be made for a pharmacist for dispensing generic drugs. It -- these, these folks are pretty savvy.
If I'm paying based on what I have submitted to HFCA at the time or CMS today on a state plan that says I will pay AWP minus 10 plus $4 or 3.91 or $4, whatever, for a brand name, and I'm setting MAC prices on the corresponding

generic that pay the pharmacist his or her net cost, it's not going to take them very long to figure out which drug to process.
When they can buy the drug at, you know, AWP minus 18, 20, 22, versus selling it at cost plus a dispensing fee, they're going, they're going to figure that out. And I'm shooting myself in the foot from a budget standpoint, from a, trying to be a responsible manager for the state's taxpayers.
So you, you want to -- you want there to be some measure of profit, some incentive over and above a dispensing fee, to incentivize pharmacists to use the generic.
Q. We'll talk about some other communications that you have had with some other state Medicaid programs, but was that issue creating a financial incentive to promote the use of multiple-source drugs something that you discussed with other state pharmacy administrators?
A. Maybe at national meetings where there

might be some, some discussion on, you know, brand versus generic, or to use a MAC or not to use a MAC.

You also have issues in different states of do they allow dispenses written? Do they have a two-line prescription form? Or what are their particular guidelines for physicians and pharmacists when it comes to being able to substitute a generic? So, but I don't remember saying, you know, I'm paying 2 cents apiece for generic penicillin, what do you pay? What -- I don't, I don't think anybody ever did that.

Q. From your experience, do you think it was well accepted amongst the Medicaid pharmacy administrative community that you would want to pay some profit on multiple-source drugs to incentivize their use?

MS. DAMOULAKIS: Objection.

A. It's just so fundamental, I don't remember discussing that with anybody. I think it's just -- it's something you -- you know, I mean it's just -- makes good sense. I don't, I

don't remember any specific discussions with anybody on, you really need to make it profitable so that they will have an incentive to use it.

BY MR. TORBORG:

Q. In your view it's just one of those fundamental tenets of how you operate a state Medicaid pharmacy program.

A. One of my bosses long ago told me that the color of health care is green, and that's true.

Q. In your time as the director of pharmacy services, did you have communications with the federal government concerning drug payments?

A. I don't know in what context you would -- I mean can you -- is there another way you can ask that question?

Q. I'll try.

In determining how much the state should be paying for drugs, both as an ingredient cost component and as a dispensing cost component, did you have discussions with the --

any representatives from CMS then known as HFCA.

A. I couldn't name any individual in HFCA or CMS, and I don't remember -- and I couldn't tell you the exact time. I would say in the, in the early Nineties HFCA putting directives out to the state, and it was, it was as if they're suggesting that, you know, we're going to be looking -- kind of giving you a heads-up, the way they would do with, with policy. That, you know, we're aware that a lot of states are, are paying AWP minus 5 or whatever. And we really think that y'all need to get to maybe 10 percent. I don't know where -- you know, if OIG or somebody gave them some number. They wanted everybody to get to 10. Or some convoluted calculation of WAC or acquisition costs or however you could get there that would demonstrate to HFCA that you're doing about AWP minus 10.

Tennessee was -- and this may -- there may be various constraints on other states. For example, some state may -- reimbursement may be subject to legislation within the state. May

have to be legislated. It may be up to the Medicaid director or the pharmacy director, it may be tied to a cost-to-dispense study from a state university, college of pharmacy, or something like that. So it -- I'm sure it varied wide, widely from state to state on their flexibility to comply with, with such a -- and it wasn't a mandate at that time. But it was -- you could clearly tell that HFCA was wanting something done with reimbursement for pharmacy services that, that I guess saved money or more closely approximated what people were really paying for drugs.

Q. You made a comment or some comments about some of the -- tell me if I'm paraphrasing you wrong here -- but there might be some roadblocks that would come between a state pharmacy director and wanted to comply with what HFCA wanted to do. Is that fair to say?

A. Well, no, ultimately, in Tennessee, for example, at that time, and really pretty much still today, two-thirds of the bill's paid by the

-- if, if actual acquisition costs is being used as a reimbursement methodology, it still does not get to net cost.

Q. During the entirety of the time that you were the director of pharmacy services for Tennessee Medicaid, did you believe that the AWPs in the compendia were a reliable source of information regarding what pharmacies or physicians actually paid for drugs?

A. No.

Q. And from your interactions with other state pharmacy administrators, in your view did other state pharmacy administrators believe that AWPs were a reliable source for what pharmacies and physicians actually paid for drugs?

MR. DRAYCOTT: Objection.

A. Again, I don't ever remember such a specific discussion with, with those peers, because it just wouldn't come up. I -- everybody knows the sky's blue. I mean it is that basic to me. I couldn't imagine some -- one of your peers in that situation sitting down and saying, Hey,

Did you know pharmacists really aren't paying AWP?

BY MR. TORBORG:

Q. So just as the sky, just as everyone knows the sky is blue, you think your peers knew that average wholesale prices did not represent a reliable source of the prices at which physicians and pharmacies actually paid for drugs.

A. That's correct.

Q. During the entirety of the time that you were the director of pharmacy services for Tennessee, did you believe that the AWPs and the compendia approximated what pharmacies or physicians actually paid for drugs?

MR. DRAYCOTT: Objection.

A. No.

No.

And "approximate" is kind of a hard term. Well, I mean I guess you could say AWP minus 22 approximates what their AWP, but I don't know how you would define approximate. But --

BY MR. TORBORG:

Q. Would that be --

A. -- the way I would look at it, I would answer no.

Q. During the entirety of the time that you were the director of pharmacy services for Tennessee Medicaid, did you believe that there was some consistent percentage by which average wholesale prices exceeded actual acquisition costs?

A. Um --

Q. Did you -- let me ask it a different way.

Did you believe that you could shave 20, 30 percent off of it and get to a reliable number of what pharmacies and physicians actually paid for drugs?

A. Well, it would, it would depend on -- I mean, are we talking brand or generic?

Q. Both right now. Would you draw a distinction?

A. Oh, yeah. Yeah.

Q. All right.

A. The generic drugs, you know, you could pay AWP minus 80 percent and still the pharmacist make money for some, I assume.

But AWP minus 25 might be below cost for a brand name drug for a rural pharmacy that has a very small volume. Okay? So there is, there is a difference between brand and generic.

In Tennessee, it wasn't as pronounced because, you know, what I did as part of my job, as soon as a drug became multi-source, and after OBRA '90, as soon as that drug, the multi-source version of a drug was cheaper than the brand name net-net of Medicaid rebates, we MACed it. So AWP wasn't an issue on the generic side.

Q. And why did you --

A. But to say 20-30 percent, use that number, you would have to distinguish between brand and generic.

Q. Would it be fair to say, Mr. Sullivan, that during the entirety of the time that you were the director of pharmacy services for the State of Tennessee that you knew that the AWPs

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and the Red Book and Blue Book were a particularly unreliable source for actual acquisition costs for generic drugs.
MR. DRAYCOTT: Objection.
A. That's true.
BY MR. TORBORG:
Q. And from your interactions with other state pharmacy administrators, do you believe that they knew that as well?
MR. DRAYCOTT: Objection.
A. Same answer as before. I don't remember ever discussing it. I think it's safe to assume that, though. I would assume that.
BY MR. TORBORG:
Q. Okay. And why, why would you assume that?
A. Because it's, it's such a known fact within the industry.
Q. And do you have an understanding of why it is that the AWPs in the compendia are a particularly unreliable source for actual acquisition costs for generic drugs?

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MR. DRAYCOTT: Objection.
A. No, I really don't know.
BY MR. TORBORG:
Q. Okay.
A. I mean the way -- I'll tell you my take on AWP, and this might answer your question, I'm not sure, but particularly in days gone by, maybe not so much today, AWP was a starting point for negotiations for different classes of trade. Based on volume and other issues, setting. A hospital versus a physician's office, versus a chain drugstore, versus a small independent drugstore.
Q. And are you familiar with the process of what happens to the price for a generic drug as time goes on?
A. Yes.
Q. And what is your understanding of that?
A. Well, the minute a drug loses its patent, a single-source drug loses its patent and FDA approves some generic competitor, generally there is some time period of exclusivity for that

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first approved generic competitor, six, nine months, whatever it is, depending on the drug, the potential market for the drug, the availability of raw materials and whatever else comes into play, that in that initial six- to nine-month period of time, when a competitor to the innovator drug reaches market, typically that first multi-source alternative is not dramatically less expensive than a brand name.
The brand name typically stops detailing that drug, unless there is some unusual circumstances.
The generic is sold primarily by pharmacists who are calling physicians who are substituting via the, whatever laws are allowable in each individual state, and after that period of exclusivity, then multiple competitors will arrive on the scene, usually, and the price drops dramatically.
There is a window of time there, in a Medicaid program, where you may be getting, based on calculations of A and P versus best price

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under the Medicaid drug rebate program, a 40, 50 percent rebate for the brand name drug, and 11 percent for the generic, which hadn't -- the price hadn't bottomed out on yet; there is no real competition yet on the generic side.
So it would behoove a state to continue to, to even block the generic. Not less. As a matter of fact, I have had chains upset with me because I didn't cover a generic until there were multiple competitors there, because I wanted all the utilization shift to the gener -- the brand while I was getting this 50 percent rebate until the minute that we had competition, and then I could MAC the drug on the generic side, where MAC less 11 percent rebate was less expensive to me than brand less 50 percent.
Q. You talked a little bit about the, what happens to the pricing of the pharmaceutical independent marketplace after the generic comes in. Did you have any expectation, Mr. Sullivan, regarding whether or not manufacturers would try to make sure that the prices reported in the

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compendia were matching the actual market prices as they lowered on generic drugs?
A. For multi-source drugs?
Q. Yes.
A. I had no knowledge, and I didn't care because if it was up to me, I think, as my job, to find out what the net cost was to the pharmacist.
Two things, availability, statewide, in Tennessee, of the generic, and, secondly, what are they paying? I have to know that in order to get back to what we were talking about earlier, providing the proper incentive to dispense generic for the pharmacist to do whatever intervention was necessary with either the patient or the physician, or both, to get the generic substitution accomplished.
Q. Now where would you get the information that you would use in the MAC program regarding what pharmacists were -- pharmacies were actually paying for drugs?
A. My, my system was, was not very

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sophisticated or very scientific, but nonetheless believe it to have been very effective.
What I did was, I knew I had a contact within the largest generic distributor in our area, and one of the most -- one of the more popular. Again during this time that I, that I was setting MAC prices, rather than MCOs or PBMs, the, the best deal on generic weren't coming from, from big wholesalers. They were coming from generic distributors.
So I had contacts within this one particular company who would tell me, who would first of all keep me apprized any time they, they were able to distribute new generic drugs, also give me information if, if there was some problem with an existing generic drug's availability, and also tell me and give -- send me catalogs that they sent to the pharmacists and then tell me additionally what am I looking at for this drug X, Y, Z, what does a hundred of them cost a pharmacy? I didn't look at Red Book or Blue Book or First Data; I called the people that sell it.

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Then I took that information, and never going to take at one source completely at face value, then I would call three or four -- I used independent pharmacists in different parts of the state, and I called. And I said, I understand, and I wouldn't mention that particular distributor. They never knew where I got my numbers. The pharmacists never knew where I got my numbers. But I would say, I'm thinking, I believe that you can get this new generic, or whatever it is, for five dollars a hundred, and I'm going to set the MAC at 7.50 a hundred. Does that give you any heartburn? And that's the way I did business.
These, I trusted these people, obviously. But there are three different sources there who are on the front lines in a pharmacy who are running a business, who they have a personal stake in. That's why I went to independents. And then the distributor, who is selling. And who over the course of that interaction I never found them to be anything but

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honest.
So -- and you can, you can quickly tell if you have got something set too low, the phone will ring.
So that -- and then I just -- I built in a little, 30 percent or whatever, profit to a generic MAC. But I would immediately MAC -- AWP was irrelevant. For generic drugs.
Q. And did you have a practice for doing, for doing this process for all generic drugs?
A. Yes.
Q. And you did this all by yourself.
A. Yes.
Q. One person?
A. Yes.
Q. And you had other duties as well, --
A. Yes.
Q. -- correct?
A. Yes.
Q. And tell me a little bit about --
A. Of course, you know, I, when I went to work there in '89 we already had a MAC program.

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entered into our system, and then paid eventually.
Just resistance to change, I guess.
Q. Did you -- did you have any involvement when the MAC program was first started in Tennessee?
A. It preceded me.
Q. And do you have any insight as to the amount of labor involved to get the process underway?
A. It would have been significant, but not anything like you started from square one today, because, number one, there weren't that many drugs. Weren't that many multi-source drugs. And we had a very restrictive formulary. So even if there was -- for a lot of drugs, even if there was a generic alternative, even the generic wasn't covered.
Q. When you were the director of pharmacy services, Tennessee Medicaid, from '89 through 2004, save the, the nine months, did you believe that you had no choice but to use the AWPs and

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the compendia to set payment rates for generic drugs?
MR. DRAYCOTT: Objection.
A. Had no choice. As -- well --
BY MR. TORBORG:
Q. When you say you had no choice, what do you mean?
A. That was your question, I think, you had --
Q. Did you believe that there was no other practical alternative but to use what was in the compendia --
MR. DRAYCOTT: Objection.
BY MR. TORBORG:
Q. -- to reimburse generic drugs?
A. It was, it was the most expedient is all I would say. And it was going when I got there, and I would say an industry standard that we, that we -- a wheel we couldn't reinvent.
Q. But you used a MAC program to reimburse generic drugs; is that right?
A. Yeah. Now I thought you were talking

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about brand name in your original question.
I keep the two totally separate. I have never reimbursed anybody for generic based on AWP.
Q. So would it be fair to say that you believed you had another choice to set reimbursement rates for generic drugs?
A. Oh, yes.
Q. Apart from the compendia.
A. Yes. Yes. I'm sorry.
Q. You mentioned federal upper limits in one of your previous questions. I think we both know what that's, what that's all about.
Did you become aware at any point during your work with Tennessee that CMS apparently deliberately did not establish federal upper limits for intravenous and injectable drug products?
MR. DRAYCOTT: Objection.
A. I wouldn't say that I ever knew that they intentionally didn't do that, but I -- you know, the -- I don't remember -- I don't remember

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injectables being part of the FUL, but it could have been. I, I just don't remember that.
Again, that's another thing that, in Tennessee, and I'm sure this will vary again from state to state, in Tennessee we chose, for example, in a physician's office, under certain settings, or home health is probably a better example, certainly certain drugs and other things, all of them, we wanted to run through the pharmacy program. For several reasons. The reimbursement for drugs on like a HFCA 1500 or whatever the -- would have happened from a home health agency to a home health division within TennCare to process, those folks had no clue that if -- what the difference between what was billed and what should be paid should be. So typically a hundred percent of bills was paid. So we didn't want, didn't want that situation. We wanted it to certainly be fair, but wanted most of those things to come through the pharmacy program to control costs.
So in the instance of IV solutions or

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concerns on whether or not the payment for these kind of therapies was, was adequate?
A. Well, my opinion, particularly in the, in the home health arena, was -- and during this specific time period, the growth in Tennessee was such of those type of providers that it wouldn't -- that wouldn't -- not lead you to believe that the reimbursement for Medicaid was inadequate.
When people are hollering and screaming or you have trouble getting providers to take care of your patients is when that was more likely a concern.
Q. Well, do you know when the home infusion business really started taking off?
A. Well, it certainly took off in the early Nineties. And I can't remember -- and Tennessee was a little bit different because we very purposely avoided expansion of home community based services under the Medicaid program because the vast majority of the patients who would receive those services were dual eligibles, which meant they had Medicaid and

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Medicare. And Medicare home health was, was truly exploding. We had hundreds of providers in Tennessee of home health services. I dare say there's, you know, maybe 20 now. Because there was, there was indeed a bonanza on the Medicare side in Tennessee. Other states didn't face it quite as -- if they had chosen to expand or had very aggressive home community-based services through Medicaid, might have had a little bit different policy issues. We purely shifted to Medicare, cost shifted to Medicare, with the duals. And so it wasn't maybe not as, as intense on a Medicaid issue in Tennessee as it might be elsewhere is what I'm saying.
Q. The page starting with -- at 425 and then going over to 426, there is a discussion of what some states are doing in the home IV reimbursement area, Minnesota indicates compounding or a dispensing fee of $8 for IV drugs, and then Washington indicates that they're paying a compounding amount, Ohio as well.
Do you have an understanding of what

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they're talking about when they talk about a compounding fee?
A. Yes.
Q. And what, what is that?
A. Well, certain, be it -- I mean you can compound IV drugs if you have the right equipment and filters and hoods to keep it, make it a sterile product.
And you can compound drugs for inhalation. If you have, again, the right equipment, similar to what would be in a hospital, to, to handle sterile products.
And you take the raw ingredient and mimic whatever, generally, the brand name or the innovator product was.
Q. And do you know in Tennessee, either before TennCare or after TennCare was paying a compounding fee for IV? Do you know if that was something that was being paid?
A. Ah, no. But there's, there's ways to pay it without, without having a separate -- you know, I noticed on here that one form is for

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payment, one form is for reimbursement of supplies, one form is for -- you know, they're, they're making a variety to submit multiple forms. And I wouldn't -- I can't tell you a specific product or specific time period, but one of my strategies was in issues like this, where compounding was involved, I didn't want to go down the road, at least in the early Nineties, of getting into paying for compounded prescriptions, because that can -- that could range from a sterile product all the way down to an ointment, okay?
And, and our claims reimbursement system hadn't evolved to the current NCPDP sophistication of today. So it was very hard to put in a, a set compounding fee for what, what products?
One may take a minute to make, one may take an hour and a half.
So getting back to, to the MAC issue, some, sometimes for certain products in this arena, you would take that into account for the

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MAC.
For example, I might say, I'm not paying for the tape that you use to hold the IV needle into place. I'm not paying for the IV needle or the tube set. I'm not going to -- I don't want bills for that. I know you've got to do it to administer this drug. So we're going to add on the cost of this drug X, because I know this, this and this always goes with it, and I know there is a fixed cost for that, but I don't want five bills. I want 10 different places. Bill me for the drug. And I'll make sure that the -- whatever the MAC is incorporates all your other costs. And you have to talk with providers and know what that is. I mean, you know.
Q. So, in short, you would use the payment for the drug itself to cross-subsidize other things that might need to be paid to fairly --
A. And that would include compounding.
Q. And it may include nursing services that were not included, things of that nature?
A. (Nodding yes.)

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Q. Did anyone in the federal government ever tell you that you were not allowed to do that?
A. No.
Q. And if they had told you that, what would you have said?
A. That I wasn't allowed to pay for compounding or --
Q. That you weren't allowed to use the payment for the drug to cross-subsidize those other services or supplies.
A. If they had told me I couldn't do it, what would I do?
Q. Yes.
A. I would have had to have found another way to, to handle the billing.
Q. But they never told you that.
A. No.
Q. Do you know if other states were doing -- were adopting similar type strategies to run the programs?
A. No, I don't -- I mean it may be

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addressed in this letter. I don't know. It seems to talk about different states, but I'm sure there were varying levels of complexity in the billing process, and what was and wasn't billable and what was and wasn't included, but I don't know it and I didn't discuss it with folks.
Q. Have you heard the term cross-subsidy or cross-subsidization in the context of pharmacy reimbursement?
A. No, not -- no, I haven't.
Q. I'm going to show you another, another -- going to mark that as another exhibit.
MR. TORBORG: I think this is 578.
(Exhibit Abbott 578 marked.)
BY MR. TORBORG:
Q. For the record, what we have marked as Exhibit 578 bears the Bates numbers HHC 002-0400 through 407. It's another Medicaid pharmacy bulletin. This one dated January-February of 1988.
Mr. Sullivan, if I could ask you to go to Bates page ending in 402. In particular the

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discussion on the first full paragraph about Montana Medicaid. Do you see that?
A. Yes.
Q. Where it says, Similarly, Montana Medicaid compensates for the additional time and expense of dispensing compounded drugs by allowing the provider's usual and customary charge up to 2.5 times the cost of ingredients, paren, reimbursement for other outpatient drugs is a lower of AWP minus 10 percent, or the cost of the drug, end paren. Do you see that?
A. Yes.
Q. Is that the, the type of thing that Tennessee was doing?
A. It's a different approach to -- yeah. Make -- paying the provider for the, for the compounding without -- and setting a limit on what I will pay up to two and a half percent. It's just a different, different twist.
Q. Does it -- does this refresh your recollection about any other types of approaches like this that other states were using?

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exhibit.
(Exhibit Abbott 579 marked.)
BY MR. TORBORG:
Q. For the record what we have marked as Abbott Exhibit 579, bears the Bates numbers HHC 902-0657 through 65, excluding 61 and 62.
A. Hmm.
Q. Mr. Sullivan, I take it from your reaction to the document that you're familiar with at least some of the material contained within this?
A. Well, it's just interesting that you threw this out right after you asked the previous question. That's why, what made me giggle.
Q. If you would take a look at that and let me know if you're familiar with any of these documents and then I'll ask you some questions about it.
A. Okay.
Q. I'll be starting with 660 and then working my way sort of chronologically through the document.

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A. Okay.
Yeah.
Yeah, yeah, this came from NACDS.
I don't remember seeing this. I remember the discussion. I don't remember seeing this document.
Q. Which document is that?
A. The second page.
Q. The second page?
A. This was... hmm. So yeah. Yeah, this was another good idea that didn't work.
Q. Okay. Let me try to paraphrase what I think was, what's reflected in these documents, at least in part.
A. Okay.
Q. And you can tell me if I'm wrong just to kind of speed things up.
It appears as though sometime in 1991, December 1991, Tennessee -- your, your Medicaid (c) issued a bulletin that indicated that usual and customary charges should be the amount that is no greater than the lowest contract price to

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another customer.
A. That's right.
Q. And an organization called the national association of trained drug stores took exception to that.
A. To say the least.
Q. And indicated that was not consistent with the moratorium that had been put on changes to drug reimbursement in the OBRA '90.
A. OBRA '90, yes.
Q. And then there was some communication from the regional office of HFCA to your office, or Tennessee Medicaid.
A. (Nodding yes.)
Q. And then there is some correspondence that you may not have been aware of from the regional office to HFCA headquarters.
A. Um-hum.
Q. Is that a fair recitation of what these reflect?
A. Yes.
Q. And do you recall this, this issue?

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A. Yes.
Q. Okay. Tell me what you recall about this.
A. Um, we -- I thought, that the OBRA '90 was irrelevant, but because North Carolina had a most favored nation policy, and vigorously enforced it, when I put out this bulletin saying we're going to do the same thing, NACDS was, was real upset and took the approach with HFCA that this was something new, and it had -- and it violated the OBRA '90 thing on some moratorium on changes to pharmacy reimbursement.
The -- we had some ongoing negotiations with NACDS, started out very contentious at first and wound up pretty, pretty amiable.
The, the best argument they had was our reimbursement rate with Tennessee Medicaid was pretty low, was lower than most states, and that it approached the ground level anyway, of what they were getting that moment in time, from other third-party payers. So the juice of enforcement really wasn't worth the squeeze of the benefit.

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So we backed off and never did implement the policy is really, really the way it played out.
Q. Do you know why it was -- were you involved in --
A. And then, and then when's, sometime after that, I wouldn't absolutely swear to it, but I believe then we -- that usual and customary piece, either in a bulletin, I don't want -- or maybe the state plan, something was thrown in there to the cash-paying public or to the general public, or something, some clarification of that.
Q. Were you involved in this issue yourself?
A. Yes.
Q. So even though the letter comes from Manny Martens, --
A. Yeah, I wrote it.
Q. You're the one that wrote it?
A. Um-hum.
Q. And what you were trying to do was to -- is it fair to say that what you were trying to do was to make the usual and customary charge for

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a pharmacy claim submitted by a provider --
A. Well, it was just --
Q. -- mean something real?
A. It was -- no. It was, it was simpler than that.
It was the imposition of something similar to North Carolina, which is a most favored nation clause.
If you're willing to accept AWP minus 20 plus a dollar from anybody, the State of Tennessee should get that same deal. That was what I was after. It didn't work.
Q. Did you believe comparisons to what other third-party payers were paying for drugs is a useful metric regarding what Medicaid programs ought to pay for drugs?
MR. DRAYCOTT: Objection.
A. No.
BY MR. TORBORG:
Q. And why is that?
A. Because you do have to factor in the access issue.

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Um, some providers may think that these -- that the Medicaid patients are more difficult, more time-consuming, more expensive patients to deal with. And you don't want to let that get in the way of still delivering quality care and access to care.
Q. Would it be fair to say, then, that you think that Medicaid programs ought to pay more than what other third-party payers pay?
MR. DRAYCOTT: Objection.
A. I think they need to do, within budgetary limits, all they can to assure access to the best providers in the state.
For example, if you look at orthopedic surgeons, or orthopedists, regardless of, of what an MCO and TennCare may be willing to pay those providers, they just, at one point in time just said, We don't do TennCare. So you got a heck of a problem there. Reimbursement level may have been more than any other third party, they just wouldn't participate. So you got to, you got to be careful about that.

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BY MR. TORBORG:
Q. Did your department or the state generally ever prepare studies or commission studies to compare provider acquisition costs to AWP?
A. No.
Q. Whether it be --
A. I don't think so.
Q. Do you recall the organization called Myers and Stauffer? Do any work with them?
A. I might have. I don't know.
Q. Did you -- did Tennessee Medicaid either itself or have someone else do any studies on what it cost to dispense prescription drugs in Tennessee?
A. Um, during, during my tenure, no. But I was aware -- I even had at least two that were done prior to my employment with the state. My predecessor had left, you know, in his files, and I had reviewed them, done by UT College of Pharmacy in Memphis.
Q. I wanted to ask you another question

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just very, very recently in the news as well? First DataBank's role in determining AWP in a settlement. McKesson chose not to settle and First Databank --

MR. DRAYCOTT: You are correct. There, there, there is a, I believe, a class certification occurred with respect to First DataBank.

THE WITNESS: McKesson is holding out.

MR. DRAYCOTT: There is also a settlement with respect to First DataBank.

THE WITNESS: Okay. That, that's the end of this, isn't it? This is 2000?

MR. DRAYCOTT: I'm going to let Mr. Torborg deal with your questions.

MR. TORBORG: Let me --

THE WITNESS: Okay. My, my -- the reason for saying that is, I'm more familiar with what's recently going on, and I think it's all related, okay?

BY MR. TORBORG:

Q. Well, let me bear, you know, bear down

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the document a little bit --

A. Okay.

Q. -- maybe I can refresh your recollection --

A. All right.

Q. -- about what this specific issue was in play here.

The letter refers to, in the second paragraph, a proposal that was discussed at the state pharmacy director's July 1999 national conference.

A. Right.

Q. Apparently there was a presentation made by United States Attorney Reed Stevens, HHSOF OIG associate counsel, Mary Ruden, and the Maryland MFCU director -- and MFCO is M-F-C-O -- C-U, Director Carolyn McElroy.

Do you recall at all, Mr. Sullivan, that meeting?

A. I probably was there.

Q. Do the names Reed Stevens, Mary Ruden and Carolyn McElroy ring a bell?

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A. Yes.

Q. You have attended meetings where they have been in attendance?

A. I'm sure I have.

Q. Have you had any conversations with Mr. Stevens at any point in time?

A. No. No.

Q. How about Ms. Ruden?

A. No.

Q. How about Carolyn McElroy?

A. No.

Excuse me.

Q. Look at the next paragraph. It states, Stated briefly, under impending change to current procedures, FDB will base the average wholesale price as it reports on market prices rather than the prices identified by manufacturers. Additionally, FTB will no longer report a price for a product unless its manufacturer has certified the completeness and accuracy of pricing information submitted.

Does this refresh your recollection at

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all about what -- this specific proposal?

A. Yes, sir.

Q. And as refreshed, do you -- can you tell me anything more about your recollection of this initiative?

A. Well, I just -- I'm just not sure whatever happened between then and today that is complying with that statement, whether it was or wasn't.

I think, you know, everybody might be missing the boat if, if they want to consider AWP to be an accurate assessment of what people pay for drugs.

Q. And --

A. This isn't going to fix it.

Q. And if you look further down the paragraph, the carryover paragraph on page 110, the second page of the exhibit, the sentence is that starts with More importantly. Do you see that?

A. Yes.

Q. It says, More importantly, in view of

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A. Right.
Q. And there is nothing wrong with entering into an agreement to provide for that either; right?
MR. DRAYCOTT: Objection.
A. No.
BY MR. KATZ:
Q. Okay. Now one of the prices which would be covered by 7A would be AMP; right?
A. Yes.
Q. And this provision would prevent CMS and Tennessee from disclosing Dey's AMP; right?
A. Yes.
Q. So this, this provision contemplates that Tennessee would --
A. Well, we wouldn't -- we wouldn't -- I don't think we'd even know what AMP was.
Q. Well, this provision in this contract contemplates that Tennessee might have AMP information; right?
A. Yeah. But I think practically all we ever got was unit rebate amounts.

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Q. And for a generic drug you can determine the AMP from the unit rebate amount; right?
A. You think that. I'm not positive that you can back into AMP on a generic drug by that simple calculation. I just -- I would have to look real hard at the, at the law again to see how that's calculated to make that leap.
Q. Okay. Assuming the statute --
A. It's too transparent for me. I can't believe that the manufacturers let it get into the code that way, if that's true.
Q. Assuming the statutory formula is, for instance, in 1994 unit rebate amount equals, for a generic drug, 11 percent of AMP, and if you had the unit rebate amount, you could calculate the AMP; right?
A. If that is true, then that's probably an accurate statement.
Q. And then the state would have the drug manufacturer's AMP information for generic drugs; right?

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A. They could back into it if all that is correct, yes.
Q. Okay. And you're not aware of any statute which would prevent CMS from just transferring all the AMPs directly to the state and which -- and asking the state to calculate the URAs, right?
A. No, I don't, I don't think that would ever happen.
Q. You're not aware of any statute that would prevent that, are you?
MR. DRAYCOTT: Objection.
A. Well, first, it just wouldn't -- first of all, the manufacturers aren't going to duplicate 51 times what they're sending once to CMS. It just -- it wouldn't happen.
BY MR. KATZ:
Q. Setting that aside, is there anything in the statutes, federal statutes or state statutes, which would prevent CMS from providing all the AMP information that Dey provided CMS, or any other drug manufacturer provided CMS, and

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then providing that to Tennessee?
MR. DRAYCOTT: Objection.
BY MR. KATZ:
Q. As far as you know.
A. It wouldn't happen.
I just -- it's too much work. There's 480 or however ever many manufacturers involved with 400,000 NDCs, and all the unit rebate amounts that go with that, and duplicating that 51 times, it just -- it isn't going to ha -- can't foresee -- I couldn't foresee that ever happening. I don't know that the law prohibits it from occurring, if that's your question.
Q. Okay. But you would agree with me, though, that this contract between Dey and the federal government and all states with approved Medicaid programs, such as Tennessee, provides for states keeping AMP information confidential in case they do have it; is that right?
A. Yes.
Q. Okay. And there is nothing wrong with that; right?

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A. No.
MR. DRAYCOTT: Objection.
Q. Okay.
A. And even as we've progressed through today with all the supplemental rebates, this language is pretty much identical and supplemental rebate agreements between manufacturers and the states.
BY MR. KATZ:
Q. And pursuant to supplemental rebate agreements do drug manufacturers report AMPs directly to the states?
A. Um, some might. I can't -- I think what you're more likely to see primarily on the -- supplementary rebates don't touch the generic side. So the brand name side, what you're more likely to see is some calculation may be based on utilization or formulary placement, or whatever that would be, in addition to a unit rebate amount, you've already gotten from the HCFA quarterly tape, or some way to avoid having to give you a state all that AMP data, or one of

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your PBMs, because of the lack of security that may exist there. So you're more likely to say, We want an additional percentage or number associated with a unit rebate amount, in addition to. That would take me ultimately from I know I'm getting 35 percent of the drug spend for that drug in Medicaid rebate now, I want 10 more. I want the net effect of -- whatever the calculations are, let's agree it's going to be 10 percent more.
Q. Let's suppose a state Medicaid program decided that they wanted to base a rebate on AMP but they didn't want to use the same formula as, as the federal government did for the Medicaid rebate agreement that we're looking at now. Could they then require the drug manufacturer, as far as you know, to report the AMP directly to the state?
A. They could --
MR. DRAYCOTT: Objection.
A. They could draw up a contract if the manufacturer was agreeable to make them give you

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every trade secret you got, if they want to sign it, that's --
BY MR. KATZ:
Q. Okay. I would like you to turn to Section 2 of the rebate agreement where it says Manufacturer's responsibilities.
A. I'm not sure where you are here.
MR. DRAYCOTT: Page 6.
A. Back the other way. Okay.
BY MR. KATZ:
Q. After the initial --
A. Yes.
Q. -- first few pages. Okay. You found it?
A. Yeah.
Q. Okay. Okay. I would like you to take a look through this section, and just goes on to the next page, and let me know when you're finished.
A. Okay. Starts with Manufacturer's responsibilities?
Q. Yes.

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A. Okay.
(Respite.)
A. Okay.
Q. Okay? Ready?
A. Um-hum.
Q. And one of the drug manufacturer's responsibilities is to calculate and report AMP to CMS; is that right?
A. Yes.
Q. Is there any mention of the -- Dey being required to calculate AWP in any way?
A. No.
Q. Is there any mention of Dey being required to calculate WAC in any way?
A. No.
Q. Is there any mention of AWP at all in this contract?
A. No.
Q. Is there any mention at all of WAC in this contract?
A. Not that I'm --
MR. DRAYCOTT: Besides that it's

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the Medicaid program's legal obligation to reimburse true provider acquisition costs, such an effort by the states to ensure payment is based on actual prices, it is mandatory. Do you see that?
A. Yeah, I see it.
Q. Do you recall a discussion at any meeting that state Medicaid programs have a legal obligation?
A. No. No.
Q. Was that consistent with your understanding of what was required by the state, Tennessee?
A. No.
Q. And what was your understanding of what was required?
A. Well, I mean why -- if there was a legal obligation to only reimburse true provider acquisition costs, then why do we go through the trouble of submitting state plans? You tell me what reimbursement is going to be.
Q. What do you mean by that?

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A. Well, why would -- if the federal government is saying you are legally obliged to pay no more than cost, then you tell me what cost is. Why do I bother submitting a state plan amendment that says I'm going to apply the lesser of this, or AWP minus that, or this or that or the other, that you approve if I'm legally obliged to paying cost. Obviously -- I mean you don't know what cost is. You can't -- or else you would dictate it.
Does that make sense?
Q. A little bit.
A. That's -- it's impossible to enforce, and I don't ever remember anybody ever telling me, Leo, you got a legal obligation to only pay true provider's cost. You do that and you won't have a program.
Only people that could do that is a 340B federally qualified health plan.
Q. If we go down to Paragraph 4 of this letter, or I'm sorry, toward the bottom of the page where there is an indent 4. Do you see

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that?
A. Um-hum.
Q. It states, If providers concede that reimbursement exceed acquisition costs but maintain that the surplus is necessary to cover ancillary costs of the drugs' administration, e.g., nursing or incidental supply expenses, their argument runs expressly counter to law. Under Medicaid program requirements reimbursement is dependent on the acquisition costs of the drugs, not the overhead costs involved in dispensing them.
Do you see that?
A. Yes.
Q. Okay. Do you agree with that statement?
A. No.
Q. Why not?
A. Well, I mean, in practicality, that's not the way it's done, and, and I never, I never was advised by my bosses or people from the regional office or people from central office of

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HFCA or CMS that that's the way things had to be done.
Q. And do you believe that reimbursement was limited to the actual acquisition costs of the drugs, that you would have an effective program that provided access to care to beneficiaries?
A. It would severely compromise access to care, in my opinion.
Q. And would that be true across all fifty states, in your opinion?
A. There may be some rural versus urban mix that, that might skew that, but I would think so.
Q. The next, next page, the carryover paragraph, first sentence, states, No entity charged with implementation or enforcement of Medicaid program rules can responsibly countenance a reimbursement system that violates the statutory obligation to reimburse provider acquisition costs.
Did you -- do you agree with that, Mr.

Q. Right.
A. Then, then we'd pay a hundred twenty.
Q. But if the usual and customary was a hundred.
A. Oh. And they billed it at a hundred, then we'd only pay a hundred.
Q. Okay. So --
A. You're relying, pre audits, on their honesty to bill the usual and customary.
And their computer systems do that for them.
Q. But just to be clear, Tennessee Medicaid never paid more than the usual and customary charge; right?
A. No. Never paid more than AWP minus 13.
Q. Right. But it also never paid more than the usual and customary charge.
A. We, we, we might well have.
Q. How?
A. It depended on the honesty of the billing provider. If their usual and customary was less than AWP minus 13.

Q. Let me rephrase. Let me rephrase, okay?
A. All right.
Q. Tennessee Medicaid never paid more than the amount billed by the provider; right?
A. That's, that's correct, unless -- unless there was some error in units or some -- generally speaking, yes.
Q. Okay. If there was no error --
A. There certainly are times when claims are overpaid, but it's, it's rare.
Q. Assuming everything was done correctly, Tennessee Medicaid never paid more than the amount billed by the provider; right?
A. That's correct.
Q. And the provider was not supposed -- was supposed to bill its usual and customary charge; right?
A. That's correct.
Q. Okay. And the usual and customary charge was the value it placed on the services it provided; right?

A. Yes.
Q. And so Tennessee Medicaid never paid more than the value of the serv -- the services that the provider gave to the Medicaid beneficiary; right?
MR. DRAYCOTT: Objection.
A. I can't say that with -- because I don't know the honesty level of the billing for usual and customary. If they billed me usual and customary all the time, then the only thing I would say about that, contrary to what your question says, is that, well, at least I didn't pay more than the cash-paying public did. Maybe still getting royally screwed, I don't know.
BY MR. KATZ:
Q. Okay. Let's -- let me rephrase that, then.
From the standpoint of the provider, and let's assume that there is no dispute that the provider is honest and submits its true usual and customary charge, okay? And as its usual and customary charge it submits the value it places

on the services it gives to the Medicaid beneficiary, it never receives more from Tennessee, Tennessee Medicaid than that amount; right?
MR. DRAYCOTT: Objection.
A. I'll agree.
MR. KATZ: Okay. I would like to mark this has Dey Exhibit 124.
(Exhibit Dey 124 marked.)
BY MR. KATZ:
Q. If we could just take a look at the letter and let me know when you're ready.
A. Go ahead.
Q. Okay. Do you recognize this letter?
A. I'll tell you, I remember a lot of correspondence from Dey during my time, but I --
Q. I would like you to turn to the fourth page of the exhibit.
A. Yeah. I'm on the distribution list there.
Q. Do you have any reason to doubt that you actually did receive this letter?

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BY MR. DRAYCOTT:
Q. Just a reminder, Mr. Sullivan, my name is Justin Draycott with the Civil Division of the Department of Justice. I represent the United States in this matter and I'm going to try to move this quickly.
At the outset I just repeat one of the instructions that Mr. Torborg, or really a request of Mr. Torborg made with you at the outset, which is anything I ask you is unclear, please just feel free to ask me for clarification.
The first question I have for you is, are you familiar with the term spread?
A. Yes.
Q. Well, let me back that up. Spread in the context of pharmaceutical reimbursement.
A. Yes.
Q. And do you understand that term to be the difference between a provider's acquisition cost for a drug and the amount that's ultimately reimbursed under AWP-based regimen?

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A. Yes.
Q. And when I say the term, I don't mean it in a pejorative sense, I'm just talking about the difference between the --
A. Cost.
Q. -- cost of acquiring the drug and ultimately what's reimbursed for that drug.
A. Yes.
Q. And if you could just keep that definition in mind as we move forward.
A. Okay.
Q. I'm going to direct your attention back to the first hour of your testimony with Mr. Torborg, and in particular you were testifying at that time about the period during 1989 and 1994, that is, before the TennCare regimen began. And Mr. Torborg asked you whether or not it was consistent with the fundamental principles that Tennessee Medicaid was operating on to incentivize providers by allowing some level of profit with respect to the reimbursement amount that was allowed by the state. Do you recall

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that testimony?
A. Yes.
Q. And have I characterized it approximately in a correct manner?
A. Yes.
Q. With respect to the --
A. I think that, we were speaking I believe primarily on the generic side.
Q. All right. But also I think you applied it to, yeah, to the generic, and that you were hoping to provide an incentive to move utilization to generic drugs.
A. Yes.
Q. With respect to that profit component, should your testimony be understood to mean that any level of profit that might be generated by the application of a spread, or the existence of a spread, was in accordance with the fundamental principles that Medicaid, the Medicaid program in Tennessee was operating under?
MR. TORBORG: Object to form.
A. It would, it would depend on the level

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of that profit.
BY MR. DRAYCOTT:
Q. For example, should we understand your testimony to be that if there was a thousand percent profit, for example, on a bag of water, that wouldn't necessarily, by virtue of your testimony, be something that should be considered to be consistent with the principles, the fundamental principles that operated with respect to Tennessee Medicaid at the time?
A. I would answer that question maybe two different ways. First off, depending on the cost of a product and looking at whatever the dispensing fee is, it could be that a thousand percent profit is a couple of dollars, okay? So it doesn't look quite so ridiculous, so unacceptable, from a taxpayer's standpoint.
When it, when it is, when you are talking about huge money, then that's when I failed. So to answer your question, it may be appropriate in some small percentage of cases that it would be a thousand percent profit, but I

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would, I would agree that, generally speaking, if thousands of percents of profits are being made on ingredient costs on a drug dispensed in the Medicaid program that I was overseeing, that I've made a mistake somehow, and it shouldn't be that way.
Q. That because, are you saying because you didn't have a MAC in place?
A. Either a MAC or some control on units or some edit in the system that would have prevented that occurrence.
Q. But we shouldn't, we shouldn't consider that, for example, twelve dollars offered for a one-dollar bag of sterile water, that where the acquisition cost was a dollar or dollar and a half, we shouldn't automatically assume that your testimony is meant to endorse the idea that a payment rate, if it were to occur at 12 or 15 dollars was necessarily, just because it included profit, should we necessarily assume that that was consistent with the fundamental principles that determined --

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A. No.
Q. -- appropriate reimbursement under the Medicaid program.
A. No.
MR. TORBORG: Object to form. Misstates the facts.
BY MR. DRAYCOTT:
Q. You also I think testified that setting -- you have to be careful not to set a reimbursement amount that was too low because you wanted to provide an incentive and to make sure that there was patient access to, to providers who were participating in the program.
A. Yes.
Q. Is there also a problem with creating, with reimbursement, allowing reimbursement to be too high? Did that also -- if it's, if it's -- let's consider the example of a drug for which there is an inflated amount of reimbursement because of a very high AWP, does that present, present the issue or the potential for overutilization? In other words, it would create

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its own incentives for providers.
MR. KATZ: Objection to form.
A. If a provider became aware that two competing products were reimbursed at such dramatically different levels, from a profit standpoint, yeah, that could affect prescribing patterns.
BY MR. DRAYCOTT:
Q. And is that of concern to the Tennessee Medicaid program, or was it during your tenure?
A. Well, not so much -- yes. But more back to what, what I was talking about in the previous question, that I failed. I've made a mistake somewhere for that to occur in the first place.
Q. When you say that, again it's because of not putting a MAC in place that would have completed the expenditure?
A. That's, that's the jumping off spot, yes.
Q. And that, so your failure there, as you're describing it as such, would be with

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respect to generic drugs?
A. Yes. By and large. Because the, the brand name thing is pretty much set tight at AWP discount reimbursement.
Q. Mr. Torborg also asked, showed you a paragraph in the complaint by the United States in this case in which it sets out a definition of the term AWP. More specifically, it was paragraph 42 of the complaint. Do you remember being shown that definition?
A. Yes.
Q. And you said that you didn't agree with it; is that correct?
A. Well, I had -- I guess I'd have to look at it again, but I didn't have a, a clear understanding of who the end purchaser was, I think, was where I was a little bit --
Q. Well, was your concern that the definition of AWP was not in accord with the AWPs that were reported in the compendia?
MR. TORBORG: Object to form.
A. I would like to look at it again to

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A. No.
MR. KATZ: Objection to form.
A. Nor federal matching share either.
MR. DRAYCOTT: That was my last question.
THE WITNESS: Outstanding.
MR. TORBORG: I have a couple follow-up questions. If anyone -- see if anyone else on the phone has any. Anyone?
MS. LIEBERMAN: Roxane would like to reserve the right to ask questions at a later date.
MR. DRAYCOTT: I'm not representing this witness, but I think the witness's preference, and he can state it for himself, would be to get this deposition finished today.
THE WITNESS: That's correct.
MR. TORBORG: Is there anybody else who has questions today for Mr. Sullivan? I have a couple follow-ups, but I'll wait until everyone else has had a chance to question.
MR. LYNN: This is Paul Lynn. I do not

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have any questions.
MR. JONES: This is Scott Jones. Go ahead.
MR. TORBORG: Okay.

REDIRECT EXAMINATION
BY MR. TORBORG:
Q. Mr. Sullivan, I have just a couple followup questions from the questions Mr. Draycott had asked you.
First, Mr. Draycott asked you some questions about a thousand percent spreads on drugs; correct?
A. Yes,sir.
Q. And asked you if your testimony should be seen by the jury in this case as endorsing or not endorsing such spreads and whether or not payment of a thousand percent spreads would be appropriate. Do you recall that?
A. Yes.
Q. Do you believe the better way to look at the appropriateness of a Medicaid program

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paying a margin or spread on a drug is the dollar value of the spread rather than the percentage?
A. You know, at certain ends of the scale, both need to be looked at, but I would agree that the dollar difference is something that needs to be looked at first, because, you know, a thousand percent makes headlines but doesn't mean anything if you don't have a dollar amount affixed to it.
Q. And do you think expressing spreads in terms of a percentage, like Mr. Draycott did, can oftentimes --
MR. DRAYCOTT: Objection.
BY MR. TORBORG:
Q. -- misconvey the real spread that's being paid by a Medicaid program?
A. That's possible.
Q. It may be that a spread of a thousand percent might be an appropriate amount to pay, depending on the facts and circumstances of both the drug involved and the services involved in paying those, dispensing those drugs?
A. It gets back to partially this thought

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process of not wanting the drug to merely be a commodity. So if, for example, your dispensing fee is limited to 2.50 and the drug -- and it is a very inexpensive drug, and it does cost 6 bucks to dispense that drug to a Medicaid patient, ratcheting down reimbursement based on a percentage of profit on the ingredients side may make it prohibitive for that provider to dispense the product. If that makes sense.
Q. It does.
If I could ask you to take out the United States complaint once again, Tab 19. It's paragraph 42. This is the point in the complaint that states AWP is used to refer to the price at which a pharmaceutical firm or a wholesaler sells a drug to a retail customer who then administers it to a patient; correct?
A. Yes.
Q. Mr. Draycott had asked you some questions whether or not you were aware of the legal definition of AWP; is that right? Do you recall that?

A. Yes.
Q. And before this lawsuit, have you ever heard of anyone talking about the, what the legal definition of average wholesale price would be?
A. I, I don't remember that.
Q. And --
A. And I don't claim to know what the legal definition of AWP is. If I ever implied that, I didn't mean to.
Q. Well, this is -- this paragraph says AWP is used to refer. Do you see that?
A. Yes.
Q. It goes on.
And so that means somebody is referring to AWP in a way that is calculated -- that is indicated in this complaint. Is that fair to say?
MR. DRAYCOTT: Objection. Objection.
A. That's the way I would read it.
BY MR. TORBORG:
Q. That's not the way -- you did not refer to AWP as the price at which a pharmaceutical

firm or wholesaler sold drugs to retail customers, did you?
MR. DRAYCOTT: Objection.
A. Yeah, I don't believe it to be true, but the previous statement you made, that is the way I would read it, too, is it is used by some people, or by the Blue Book, or the industry as, you know, the price that it's -- I believe people would say that, but that's not actually true sometimes.
Q. And that's not how -- you never used AWP to refer to the price at which pharmaceutical firms or wholesalers sold drugs to customers?
A. Actually paid for it, no.
Q. So Mr. Draycott and the other Department of Justice lawyers may use it to refer to that, but that's not what you use to refer to it; is that right?
MR. DRAYCOTT: Objection.
A. I don't think AWP is the price a drugstore pays for, for a drug.
BY MR. TORBORG:

Q. And from your interactions with other state pharmacy administrators, do you believe that they use AWP to refer to the actual price at which pharmaceutical firms or wholesalers sold drugs to customers?
MR. DRAYCOTT: Objection.
A. I would just say globally that I don't think any pharmacist practicing retail pharmacy in particular ever believed AWP to be what people paid for drugs.
MR. TORBORG: That's all the questions I have. Thank you very much.
MR. DRAYCOTT: We are concluded.
THE WITNESS: Thank you.
MR. DRAYCOTT: Thank you very much.
VIDEOGRAPHER: This concludes the deposition of Leo Sullivan, Volume 1. The number of tapes used was five. Going off the record. Time now is 16:47.
(Deposition concluded at 4:47 p.m.)

SIGNATURE OF THE WITNESS

_____
HARRY LEO SULLIVAN

Subscribed and sworn to and before me this _____ day of _____, 20____.

_____
Notary Public